

Health Insurance: A Primer

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Summary

People obtain insurance to protect themselves against the possibility of financial loss in the future. Health insurance provides protection against the possibility of financial loss due to high health care expenses. Also, people do not know ahead of time exactly what their health care expenses will be, so paying for health insurance on a regular basis helps ease their out-of-pocket spending.

While health coverage continues to be mostly a private enterprise in this country, government plays an increasingly significant role. Government has initiated and responded to dynamics in medicine, the economy, and the workplace through legislation and public policies. One of the most recent efforts was enactment and ongoing implementation of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended). ACA includes provisions to encourage the expansion of health insurance coverage, and establish new federal health insurance standards, among other reforms.

Americans obtain health insurance in different settings and through a variety of methods. In 2013, a majority (64.2%) of Americans obtained health insurance through the private sector, which includes both employer-sponsored and individual market coverage. Public programs (Medicare, Medicaid/CHIP, or health services for military servicemembers and veterans) provided coverage to 34.3% of Americans. Approximately 13.4% of Americans were uninsured for the entire year of 2013.

Health insurance benefits are delivered and financed under different systems. The factors that distinguish one delivery system from another are many, including how health care is financed, how much access to providers and services is controlled, and how much authority the enrollee has to design her/his health plan. To illustrate, managed care is characterized by predetermined restrictions on accessing services and providers, whereas individual decision-making regarding use of health benefits is a hallmark of consumer driven health care, such as health savings accounts. As economic conditions change, a specific delivery system may gain or lose the interest of affected parties.

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Introduction

As health insurance coverage has evolved from an uncommon benefit to a routine one, government's role in subsidizing and regulating that coverage also has changed. While most insured Americans obtain health coverage through the private sector, public entities play an increasingly significant role.

The federal government's involvement in health coverage expanded dramatically over the past several decades:

- A long-standing rule issued by the Internal Revenue Service (IRS) in 1954 stated that an employer's contributions to employer-sponsored health insurance are not to be included in an employee's gross income for tax purposes (Internal Revenue Code, Section 106). This ruling helped spur the growth of employer-sponsored health benefits. The IRS also stated separately that employers could deduct such contributions as part of business expenses.
- Advances in medicine led to increased costs of treatment, which was especially problematic for certain groups of consumers who lacked health coverage. This led to government efforts to assist health care consumers in paying for medical services through the 1965 Medicare and Medicaid social insurance programs.¹
- More and more employees began to work for more than one employer over their lifetimes. The federal government enacted the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to provide certain protections to workers that switched or lost jobs.
- In response to a persistent rate of uninsurance, the federal government in 2010 passed the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), which instituted a large set of reforms to the private insurance market and expanded publicly funded coverage.

Given the frequent introduction of legislation aimed at modifying or building on the current health insurance system, understanding the potential impact of such proposals requires a working knowledge of how health insurance is provided, purchased, and regulated. This report provides background information about these topics.

What Is Health Insurance?

Definitions and Principles

People buy insurance to protect themselves against the possibility of financial loss in the future. Such losses may be due to a motor vehicle collision, natural disaster, or other circumstance. For individuals, financial losses may result from the substantial² use of health care services. Health insurance provides protection against the possibility of financial loss due to high health care

¹ Publicly funded health programs generally either provide funding for direct medical services or assist consumers in paying for health care. The latter are included in a broad category of programs based on social insurance principles. Social insurance refers to publicly funded insurance programs that are statutorily mandated for certain groups of people, such as low-income individuals.

² Either in terms of multiple services due to a chronic condition or a single use due to an emergency condition.

expenses. Also, people do not know ahead of time exactly what their health care expenses will be, so paying for health insurance on a regular basis helps to smooth out their spending.

The concept underlying insurance is *risk* (i.e., the likelihood and magnitude of financial loss). In any type of insurance arrangement, all parties seek to minimize their own risk. In health insurance, consumers and insurers approach the management of insurance risk differently. From the consumer's point of view, a person (or family) buys health insurance to protect against financial losses resulting from the future use of medical care. From the insurer's point of view, it employs a variety of methods to manage the risk it takes on when providing health coverage to consumers, to assure that it operates a profitable business.³ One method is to charge higher premiums for older consumers (to the extent allowed under federal law), because medical expenses tend to increase with age. While the methods employed by an insurer differ from those of a consumer, each has the same goal: to minimize risk in an uncertain future. It is this uncertainty of the future and risk of financial loss which form the context for insurance, and the strategies to make financial loss more predictable and manageable which drive insurance arrangements.

Risk Pools

A function of insurance is to spread risk across a group of people. This is achieved in health insurance when people contribute to a common pool (*risk pool*) an amount at least equal to the *expected* cost resulting from use of covered services by the group as a whole. In this way, the *actual* costs of health services used by a few people are spread over the entire group. This is the reason why insuring larger groups is considered less risky—the more individuals participating in a risk pool, the less likely that the serious medical experiences of one or a few persons will result in catastrophic financial loss for the entire pool.

An insurer calculates and charges a premium in order to finance the health coverage it provides. The premium reflects several components, including the expected cost of claims for health care use in a year, administrative expenses associated with running the plan, and a profit margin.⁴ If the insurer accurately estimates future costs and sets appropriate premium levels for all enrollees, then that risk pool has reached equilibrium. This equilibrium is often achieved by healthy persons in the risk pool helping to subsidize the higher-than-average costs of less-healthy persons in the pool.

This redistributive effect is a primary feature of insurance, because it is generally understood that a minority of consumers is responsible for a majority of expenses. According to an analysis of national health care expenditure data, the top 5% of the population accounted for nearly half of all health expenditures in 2011 and 2012.⁵ Because of this uneven distribution of expenses, in a risk pool it would be expected that costs attributed to those who incur the greatest expenses would be spread across the pool.

³ While nonprofit organizations also provide health insurance in this country, such organizations nonetheless are interested in containing expenses, even if they do not have a profit motive.

⁴ The premium calculation is further adjusted to reflect a variety of factors collectively known as the underwriting cycle.

⁵ S. Cohen, "The Concentration and Persistence in the Level of Health Expenditures over Time: Estimates for the U.S. Population, 2011-2012," September 2014, http://meps.ahrq.gov/mepsweb/data_files/publications/st449/stat449.pdf.

Risk Pool Composition and Adverse Selection

As noted above, one of the ways insurers attempt to make future costs more predictable is by spreading the risk of a few high-cost individuals across many people. But the number of people in a risk pool is not the only significant factor. Equally as important, if not more so, is the composition of the group.

A consumer's intention to obtain health coverage is based on a variety of factors, such as individual health status, estimated need for future medical care, and disposable income. Consumers with different health conditions, as well as varying degrees of comfort towards risk-taking, will differ on whether they consider health insurance necessary. However, with many companies offering their workers an employer subsidy for insurance plans, even those unlikely to incur significant medical expenses are incentivized to obtain coverage under this arrangement, if it is available to them. Because consumers are required by law (with certain individuals excepted) to either obtain insurance or face a penalty, their willingness to pay this penalty will also factor into their decision.⁶

Individuals who expect or plan for high use of health services tend to enroll in more generous (and consequently more expensive) health plans, a phenomenon known as *adverse selection*. An extreme example of adverse selection is when a disproportionate share of unhealthy people makes up a risk pool and the cost for each person in the pool rises. The higher costs may encourage the departure of healthier members and discourage the entrance of other healthy people, since healthier people may be able to find cheaper coverage elsewhere or decide that coverage is too costly and become uninsured (and pay a penalty). In either situation, it leaves an even less healthy group of people in the risk pool, which again causes the cost to rise for the remaining participants. If there is no change in this dynamic, the group may experience a self-reinforcing rise in costs as it suffers substantial adverse selection, leading to an increasingly expensive risk pool and possibly dissolution of the pool altogether.

Group and Non-group Market

Health insurance can be provided to groups of people that are drawn together by an employer or other organization, such as a union. Such groups are generally formed for some purpose other than obtaining insurance, like employment. When insurance is provided to a group, it is referred to as *group coverage* or *group insurance*. In the group market, the entity that provides health benefits to the group (e.g., an employer) is referred to as the plan *sponsor*.

The group insurance market is divided into two segments, small group and large group, defined by the size of the employer or other organization purchasing a group insurance plan. Since some ACA reforms focus specifically on the small group insurance market, it is important to note the distinction in size between the small and large group markets. Before enactment of the ACA, the dividing line between small and large groups was typically 50 employees. In 2016, the dividing line will increase to 100 employees. Thus businesses with fewer than 100 employees will be defined as *small employers* and be eligible for small group coverage. Until the 100 employee large group definition takes effect in 2016, ACA allows states to choose whether to define *small employers* as those that employ 100 or fewer employees or those that employ 50 or fewer employees.⁷

⁶ For additional information on the individual mandate under ACA, see CRS Report R41331, *Individual Mandate Under the ACA*.

⁷ For additional information on the ACA's insurance standards, see CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*.

Consumers who are not associated with a group can obtain health coverage by purchasing it directly from an insurer in the non-group (*individual*) insurance market. The individual market enrolls many people who do not receive coverage from an employer—those who are self-employed, unemployed, or work part-time, and who are otherwise ineligible for public insurance programs like Medicare or Medicaid.

Fully Insured vs. Self-Insured Plans

A common distinction made between types of group health insurance products is whether they are fully insured or self-insured. A fully insured health plan is one in which the plan sponsor purchases health coverage from a state-licensed insurance carrier. The carrier assumes the risk of providing health benefits to the sponsor's enrolled members and the individuals/families directly purchasing individual insurance policies. In contrast, organizations that self-insure (or self-fund) do *not* purchase health coverage from insurers. Self-insured plans refer to health coverage that is provided directly by the organization seeking coverage for its members (e.g., a firm providing health benefits to its employees). Such organizations set aside funds and pay for health benefits directly. Under self-insurance, the organization bears the risk for covering medical expenses, and such benefit plans are not subject to state insurance regulations.⁸ Firms that self-insure may contract with third-party administrators (TPAs) to handle administrative duties such as member services, premium collection, and utilization review. TPAs do not underwrite insurance risk.

Self-Only vs. Family Coverage

Another common distinction made in health insurance refers to the scope of coverage provided under a health plan; that is, whether the coverage is for one person, a family, or other groupings. Under self-only coverage, the holder of the insurance policy is the only person insured. (Self-only coverage is also called individual coverage. Individual coverage in this sense should not be confused with health coverage from the individual insurance market—see discussion above.) Family coverage applies to the policyholder and his or her dependents. Other coverage arrangements may include self plus one, and self plus children.

Tax Exclusion for Employer-Sponsored Insurance

Health insurance coverage in the United States is delivered through a patchwork approach, which includes private and public sources, of providing and paying for health insurance and health care. One of the key pieces of this approach encouraged the growth of employer-sponsored health coverage via the tax code.⁹

Section 106 of the Internal Revenue Code states that employer contributions to employer-sponsored health insurance are not included in workers' gross incomes for tax purposes. This tax preference encourages workers to sign up for (*take-up*) health coverage within the work setting. Moreover, employers' premium contributions are excluded from wages for the purpose of calculating employment taxes, which include Social Security and Medicare taxes, and unemployment taxes.¹⁰ Exclusion of these contributions directly affects the amounts that

⁸ For further discussion, see "Regulation of Health Insurance."

⁹ The federal tax code contains many health-related provisions that provide tax advantages to certain individuals, employers and workers, for both the purchase of health coverage and unreimbursed medical expenses. For additional information about health-related tax benefits, see Joint Committee on Taxation, "Tax Expenditures for Health Care," July 30, 2008, available at <https://www.jct.gov/publications.html?func=select&id=5>.

¹⁰ 26 U.S.C. §§3121(a)(2), 3231(e)(1), and 3306(b)(2).

employers and workers pay in taxes. In addition to the tax advantages, employer-sponsored health coverage allows both parties to benefit in other ways: employers use health insurance coverage as a means to recruit and retain workers, while workers have traditionally gained access to more plan choices at better rates than those seeking non-group insurance (see discussion below). However, economic theory suggests that workers receive reduced wages to compensate for richer benefits.

The tax exclusion of health benefits is one of the primary reasons why health insurance coverage is provided mainly through the workplace in the United States. For example, approximately 53.9% of Americans had employer-sponsored insurance in 2013.¹¹ Furthermore, the tax exclusion of employer-sponsored insurance is the largest single tax expenditure by the federal government. The Congressional Budget Office estimated that the employer-sponsored health insurance exclusion from both income and payroll taxes would cost the government \$248 billion in 2013.¹²

Health Insurance Premiums

A person enrolled in a private health insurance plan must pay a fee (*premium*), typically on a monthly basis, to maintain coverage under the plan. An insurer will then pay for a certain proportion of health care services and items at the time they are received (after the plan's deductible is met, if applicable), with the enrollee paying the rest of the cost out of pocket, an arrangement known as cost-sharing.

Premiums are used for three general purposes: payments for medical claims, administrative costs, and a profit margin. Claims payments make up the largest component of premiums, ranging from 85% to 88% of fully insured plans between 2006 and 2011.¹³ The magnitude of claims payments is a function of both the *quantity* of health services (e.g., hospital visits) and items (e.g., prescription drugs) used and the *price* for each corresponding service and item (less any applicable enrollee cost-sharing), with rising prices, not quantity, generally being the main driver of total payments.¹⁴ Administrative costs and a relatively modest profit margin—less than 5% in recent years¹⁵—make up the rest of premiums.

Premiums for U.S. insurance plans are difficult to summarize not only because plans can be arranged on behalf of a group by an organization such as an employer or purchased individually under a different set of regulations, but also because plans can cover a single person (self-only coverage), an entire family, or some combination in between. In addition, reliable premium information, especially for the non-group market, can be difficult to find. Also, comparing premiums between groups is difficult considering the products (i.e. insurance) varies.

An annual source of employer health benefits data found that the average annual premium for self-only coverage was \$6,025 in 2014. The average premium for a family of four was \$16,834

¹¹ U.S. Census Bureau, Current Population Survey, “Health Insurance Coverage in the United States: 2013,” September 2014, available at <http://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-250.pdf>.

¹² Congressional Budget Office, “Options for Reducing the Deficit: 2014 to 2023,” November 2013, available at <http://cbo.gov/sites/default/files/cbofiles/attachments/44715-OptionsForReducingDeficit-3.pdf>.

¹³ Debra A. Donahue, “Medical Expense Trend Up in 2011,” Mark Farrah Associates, February 12, 2013, available at <http://www.markfarrah.com/healthcare-business-strategy/Medical-Expense-Trend-Up-in-2011.aspx>.

¹⁴ Health Care Cost Institute, “2013 Health Care Cost and Utilization Report,” October 2014, <http://www.healthcostinstitute.org/files/2013%20HCCUR%2012-17-14.pdf>.

¹⁵ Debra A. Donahue, “Medical Expense Trend Up in 2011,” Mark Farrah Associates, February 12, 2013, available at <http://www.markfarrah.com/healthcare-business-strategy/Medical-Expense-Trend-Up-in-2011.aspx>.

that same year.¹⁶ For self-only coverage, the cost of employer-sponsored health benefits was similar to the prior year. Compared to the previous year's average premiums, the cost for employer-sponsored health benefits for family coverage increased 3%. While this signals a reprieve from the double-digit increases that have occurred in the past, average premium growth rates still outpaced both wage growth and general inflation.¹⁷

Non-group premiums have also risen in recent years. For instance, the individual market saw its national average rate of premium increase grow from 9.9% to 11.7% between 2008 and 2010.¹⁸

Administrative Expenses

Health insurance companies are complex organizations requiring specialized expertise and technology to develop, market, and operate a health plan. Administrative expenses include costs associated with contracting with providers, sales and marketing, enrollment and billing, customer service, utilization review, case management, and other functions. Given that administration is an essential component of an insurer's business, such expenses comprise an integral component of premiums.

Insurance companies report administrative costs in regulatory filings to applicable state entities. Such data indicate a relatively stable trend. From 2009 to 2013, general administrative expenses and claims adjustment expenses together took up between 11.7% and 12.1% of health insurers' net written premiums.¹⁹

Regulation of Health Insurance

Health insurance regulation addresses a wide variety of issues: the benefits that must be offered, the individuals to whom the insurance is made available, and the responsibilities insurers have to consumers, to name a few. One of the most enduring issues regarding health insurance regulation is whether it is the responsibility of individual states or the federal government.

Primary Responsibility of the States

The regulation of insurance traditionally has been a state responsibility, as clarified by the 1945 McCarran-Ferguson Act. Individual states have established standards and regulations overseeing the *business of insurance*, including requirements related to the finances, management, and business practices of an insurer. For example, all states have laws that require state-licensed insurance carriers to offer coverage for specified health services (*benefit mandates* or *mandated benefits*). Because fully-insured plans are subject to state-established requirements, those plans must offer those mandated benefits. On the other hand, self-insured plans are not subject to state insurance regulations so they are exempt from such requirements.

¹⁶ These averages include both the employer and employee shares of the total premium. The Kaiser Family Foundation and Health Research and Educational Trust, *2014 Employer Health Benefits Survey*, available at <http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report>.

¹⁷ Ibid.

¹⁸ Jonathan Gruber, "Growth and Variability in Health Plan Premiums in the Individual Insurance Market Before the Affordable Care Act." The Commonwealth Fund. June 2014. Available at http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/jun/1750_gruber_growth_variability_hlt_plan_premiums_ib_v2.pdf.

¹⁹ National Association of Insurance Commissioners, "2013 Health Insurance Industry Analysis Report," available at http://www.naic.org/documents/topic_insurance_industry_snapshots_2013_industry_analysis_report.pdf.

Key Federal Laws

Despite the states' role as the primary regulators of health insurance, overlapping federal requirements complicate regulation of the health insurance industry. Three federal laws in particular—the Employee Retirement Income Security Act of 1974 (ERISA; P.L. 93-406), the Health Insurance Portability and Accountability Act of 1996 (HIPAA; P.L. 104-191), and the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended)—have a significant impact on how private health insurance is provided.

ERISA outlines minimum federal standards for private-sector employer-sponsored benefits. (Public employee benefits and plans sponsored by churches are exempt from ERISA.) Passed in response to abuses in the private pension system, the act was developed with a focus on pensions but the law applies to a long list of *welfare benefits*, including health benefits. ERISA requires that funds be handled prudently and in the best interest of beneficiaries, participants be informed of their rights, and there be adequate disclosure of a plan's financial activities. It preempts state laws that *relate to* employee benefit plans. (In other words, the federal law overrides state laws affecting private-sector employee benefits.) This portion of ERISA was designed to ensure that plans would be subject to the same benefit laws across all states, partly in consideration of firms that operate in multiple states. However, state laws still apply for issues which involve the *business of insurance*. The delineation of issues attributable to the phrases *relate to* and *business of insurance* is not clear, and has led to long-standing debates and active litigation over the scope of ERISA preemption.²⁰

The core motivation behind the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was to address the concern that insured persons had about losing their coverage if they switched jobs or changed health plans (*portability* of health coverage). The act's health insurance provisions established federal requirements for private and public employer-sponsored health plans and insurers. These requirements included

- ensuring the availability and renewability of coverage for certain employees and other persons under specified circumstances,
- limiting the amount of time that coverage for preexisting medical conditions can be excluded, and
- prohibiting discrimination on the basis of health status-related factors.

The act also includes tax provisions designed to encourage the expansion of health coverage through several mechanisms, such as authorizing tax-advantaged medical savings accounts, and a graduated increase of the portion of premiums self-employed persons may deduct from their federal income tax calculations.²¹ Another set of HIPAA provisions addresses the electronic transmission of health information and the privacy of personally identifiable medical information (administrative simplification and privacy provisions, respectively).²²

The 111th Congress passed comprehensive health reform legislation: the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended). Enacted on March 23, 2010, and

²⁰ For additional information about ERISA, see the Department of Labor's overview document for a summary and relevant links, <http://www.dol.gov/dol/topic/health-plans/erisa.htm#doltopics>.

²¹ For additional information about this tax deduction, see Internal Revenue Service, IRS Tax Tip 2013-43, March 28, 2013, available at <http://www.irs.gov/uac/Newsroom/Dont-Miss-the-Health-Insurance-Deduction-if-Youre-Self-Employed>.

²² For FAQs regarding HIPAA's health insurance provisions, see http://www.dol.gov/ebsa/faqs/faq_consumer_hipaa.html.

subsequently amended by a number of laws (including the Health Care and Education Affordability Reconciliation Act of 2010; P.L. 111-152), ACA includes private insurance provisions that impose new requirements on individuals,²³ employers, and health plans;²⁴ and provides financial assistance to certain individuals²⁵ and, in some cases, small employers.²⁶ These provisions include market reforms that impose certain requirements on private insurance plans and sponsors of insurance; establish insurance exchanges (*marketplaces*) where individuals and small businesses²⁷ can shop for and purchase health plans that meet or exceed federal standards; provide subsidies to certain individuals purchasing insurance from an exchange; establish an individual mandate for most individuals to purchase insurance or pay a penalty; and assess penalties on certain employers that do not provide insurance for their employees that meets preset standards of affordability and value.

Sources of Health Insurance

Americans obtain health insurance through a variety of methods and from different sources (see **Figure 1**). People may get it through the private sector or from a government source. Consumers may purchase health coverage on their own, as part of an employee group, or through a trade or professional association. Individuals can also have multiple sources of coverage in a year. That is, they may have multiple types of coverage at one time or even switch coverage types within a year.²⁸ This report discusses health insurance coverage in three categories: (1) insured through private sources,²⁹ (2) coverage under public programs,³⁰ or (3) uninsured.

²³ For additional information, see CRS Report R41331, *Individual Mandate Under the ACA*.

²⁴ For additional information, see CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*.

²⁵ For additional information, see CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA) in 2014*.

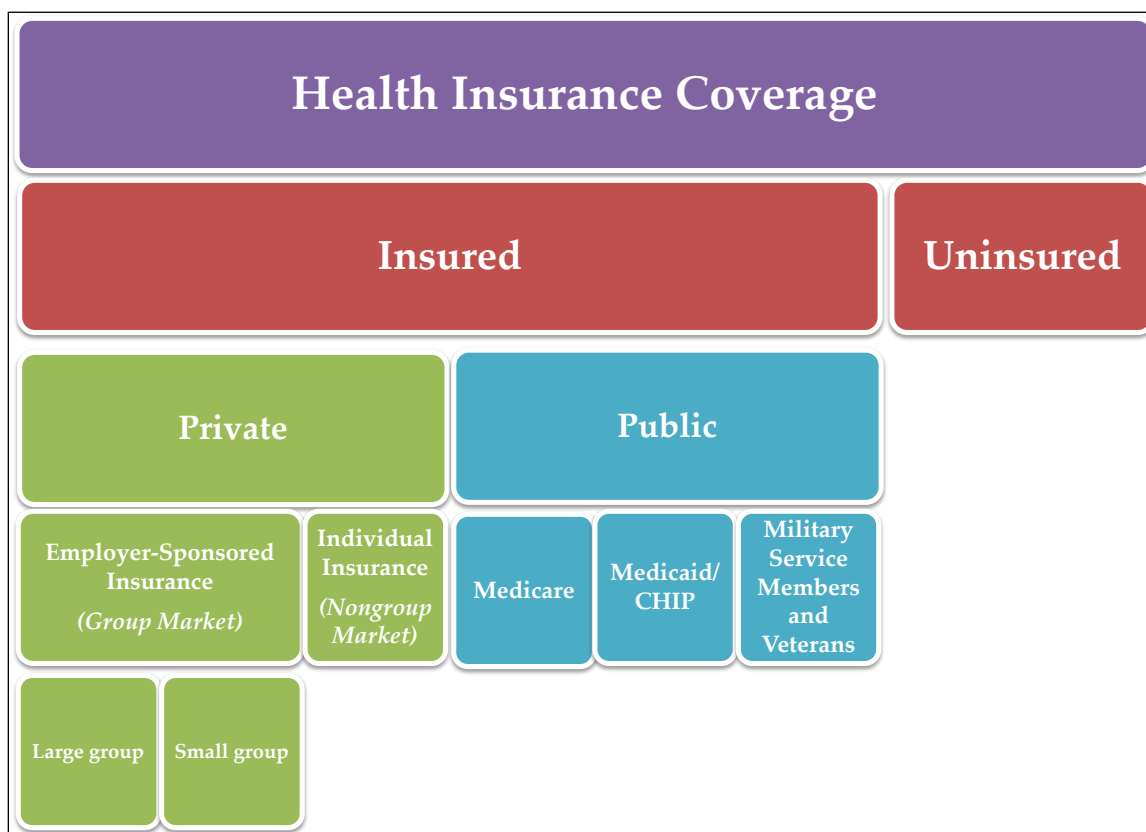
²⁶ For additional information, see CRS Report R41158, *Summary of the Small Business Health Insurance Tax Credit Under ACA*.

²⁷ For additional information, see CRS Report R43771, *Small Business Health Options Program (SHOP) Exchange*.

²⁸ Individuals may report more than one source of coverage, and individuals may report both private insurance and insurance through public programs; therefore, percentages presented in this report total to more than 100.

²⁹ Private health insurance includes employer-sponsored insurance and individual market insurance.

³⁰ Public programs include Medicare, Medicaid and other means-tested public programs (e.g., the State Children's Health Insurance Program, CHIP), and health care services for military servicemembers and veterans (e.g., TRICARE).

Figure 1. Sources of Health Insurance

Source: Congressional Research Service (CRS) illustration of sources of health insurance coverage.

Notes: This figure is not drawn to scale; it is an illustration of the sources of health insurance and does not reflect their relative sizes.

Private Insurance

Private insurance, which includes both employer-sponsored (*group market*) and individual market (*non-group*) coverage, accounts for the substantial majority of Americans with health insurance. In 2013, approximately 201 million individuals (64.2% of the U.S. population) received coverage through private insurance.³¹

The ACA introduced a number of significant reforms to the private insurance market, mostly directed to the individual and small group markets. Collectively, ACA's market reforms have substantially altered the landscape for private insurance.

Employer-Sponsored Insurance

Group health insurance is typically offered by employers, and most Americans obtain health coverage through the workplace. In 2013, approximately 169 million persons had employer-

³¹ U.S. Census Bureau, Current Population Survey, "Health Insurance Coverage in the United States: 2013," September 2014, available at <http://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-250.pdf>.

sponsored health insurance (ESI), which accounts for approximately 53.9% of the total U.S. population.³²

Under ESI, risk pools may be comprised of active workers, dependents, and retirees. Insurers use a number of strategies to increase the likelihood that each risk pool includes a good proportion of healthy individuals. For instance, insurers may restrict employees' opportunities to take up health coverage or switch health plans by designating a specific time frame each year for such activities (*open enrollment period*). This strategy decreases the likelihood that people will *game* the system by taking up coverage only when they plan on using health services (e.g., for pregnancy and childbirth), and dropping coverage when they no longer plan to access care.³³ Employers also use strategies to encourage insurance take-up by healthy people. For example, employers typically make contributions that cover most of the health insurance premium. In 2014, employers paid more than 80% of the total premium amounts for self-only plans and more than 70% for family plans, on average.³⁴ This subsidy makes health coverage a more attractive benefit, even to those workers who do not plan to use medical services on a regular basis. By encouraging healthy workers to take up health insurance, the employer subsidy helps to avoid adverse selection and contributes to the stability and diversity of the risk pool.

ESI has a number of strengths from the worker perspective. The employer premium contribution is exempt from individual income taxes, so workers are given a tax advantage by purchasing coverage through an employer compared with the individual insurance (*non-group*) market. In addition, employer-sponsored coverage typically is heavily subsidized, so workers generally do not directly bear the full cost of insurance. Both the tax advantages and employer subsidy encourage the growth and continuity of ESI, historically providing an advantage over the individual market.³⁵

For plan sponsors, health benefits are a common component of employee compensation used toward the recruitment and retention of workers. In addition, employers' premium contributions are excluded from wages for the purpose of calculating employment taxes, which directly affects the taxes owed by employers (and workers). Moreover, large employers that offer health coverage that meets certain standards will have complied with the ACA employer requirements, thus avoiding the employer tax for noncompliance. Finally, certain small employers are eligible for small business tax credits if they contribute at least half of their employees' health insurance costs.³⁶

While there are many advantages to obtaining ESI coverage, there are challenges as well. From the vantage point of the enrollee, one of the biggest disadvantages is the general lack of portability. Because ESI coverage is tied to the job and not the person, a change in employment (such as going from full-time to part-time status, or changing jobs) may alter the health care providers or services to which the worker has access, or disrupt health coverage altogether. Also, in firms that offer health coverage, there is a trade-off made between wages and benefits. For

³² U.S. Census Bureau, Current Population Survey, *op. cit.*

³³ Under the ACA's individual mandate, those who decline coverage from an employer and do not take up any other coverage may be subject to a penalty. For additional information, see CRS Report R41331, *Individual Mandate Under the ACA*.

³⁴ The Kaiser Family Foundation and Health Research and Educational Trust, *2014 Employer Health Benefits Survey*, available at <http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report>.

³⁵ ACA's reforms to the non-group market and establishment of exchanges and tax credits are policy levers to make the non-group market behave more like the large group market. See the section titled "Individual Health Insurance" in this report for additional information about these issues.

³⁶ For additional information about small business tax credits under ACA, see CRS Report R41158, *Summary of the Small Business Health Insurance Tax Credit Under ACA*.

workers who do not take up health insurance from those firms, they end up accepting lower wages for a set of benefits they do not use. From the perspective of the plan sponsor, an underlying challenge is the lack of enrollee awareness of the true costs of health care. Because the sponsor usually contributes to the cost of the premium, enrollees do not bear the full cost of obtaining health coverage. Given this lack of awareness regarding total costs, sponsors' efforts to constrain their own health spending—by increasing the employee share of the premium or cost-sharing—are made even more difficult to justify or implement. Finally, from the perspective of the federal budget, the tax exclusion of employer-sponsored health insurance represents the largest source of foregone revenue.

Individual Health Insurance

The individual insurance (*non-group*) market is referred to as a *residual* market, because it provides coverage to those who either cannot obtain health insurance through the workplace (i.e., employer-sponsored insurance) or do not qualify for public programs like Medicare, Medicaid, or the State Children's Health Insurance Program (CHIP). The residual nature of the individual insurance market is reflected in the demographic make-up of those who purchase coverage from it: many individuals with non-group insurance are part-time workers, part-year workers, and self-employed persons—individuals who are unlikely to have access to employer coverage. In addition, some people use the individual insurance market as a temporary source of coverage, such as those in-between jobs or early retirees who are not yet eligible for Medicare.³⁷ The enrollee population of the market has also historically been small, with just 11% of the U.S. population covered by insurance purchased from the individual market in 2013.³⁸

The insurance market reforms in the ACA specifically target the individual insurance market (as well as the small group market), in large part because the individual market lacked the advantages and protections compared with the large group market. Prior to ACA, individuals could be denied insurance altogether, charged a higher premium because of individual characteristics, and face benefit exclusions based on preexisting health conditions (if allowed under state law). State law varied greatly in terms of patient protections. ACA's market reforms and exchange provisions, which build on an existing but limited federal floor of insurance standards, affect the offer, issuance, generosity, and pricing of health plans, among other issues.³⁹ For example, ACA established a new tax credit that qualified individuals and families may use toward the purchase of insurance through exchanges.⁴⁰ Collectively, the market reforms and exchanges have transformed the plans and carrier practices in the individual insurance market, and standardized (to some degree) the patchwork of health regulation across the country.⁴¹

The ACA requires the establishment of a health insurance exchange in every state. ACA exchanges are marketplaces where individuals and small businesses can shop for and purchase private health insurance. The exchanges are intended to simplify the health insurance purchasing process and assist individuals in shopping for qualified health plans, applying for premium

³⁷ Kaiser Family Foundation, "Survey of People Who Purchase Their Own Insurance," June 2010, <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8077-r.pdf>.

³⁸ U.S. Census Bureau, Current Population Survey, *op. cit.*

³⁹ For a discussion of these and other insurance market reforms in the ACA, see CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*.

⁴⁰ See CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA) in 2014*.

⁴¹ Private health insurance is primarily regulated at the state-level. The ACA establishes uniform requirements and additional options for all states.

subsidies, enrolling in individual health plans, and even determining whether they qualify for Medicaid or other government programs. States can choose to run their own exchange, opt for a state-federal partnership, or have a federally facilitated exchange.⁴²

Enrollment in the individual insurance market overall may increase due to ACA's market reforms, health insurance exchanges, and tax credits. The Congressional Budget Office and Joint Committee on Taxation project that by 2024, 25 million people under age 65 will be covered by non-group insurance purchased from exchanges, representing a net increase in non-group coverage of about 20 million.⁴³

Public Programs

While most Americans with health insurance obtain it through the private sector, 107.6 million (34.3% of the U.S. population) people got health coverage through programs administered by the government in 2013.⁴⁴ Below are descriptions of selected public programs which provide health insurance coverage to eligible persons.

Medicare

In 2013, almost 49 million (15.6% of the U.S. population) individuals obtained coverage through Medicare.⁴⁵ The Medicare program was established in 1965, and is a federal program for persons age 65 and older and certain persons with disabilities. Medicare consists of four parts: Part A, Hospital Insurance; Part B, Supplementary Medical Insurance; Part C, Medicare Advantage; and Part D, the prescription drug benefit. The Medicare program provides coverage for a wide range of medical services, such as care provided in hospitals and skilled nursing facilities, hospice care, home health care, physician services, physical and occupational therapy, outpatient prescription drug benefits, and other services. Medicare has been so successful in covering the elderly that the problem of uninsurance usually is described in terms of the under-65 population.⁴⁶

Medicaid and the State Children's Health Insurance Program

Medicaid covered approximately 54.1 million people (17.3% of the U.S. population) in 2013.⁴⁷ Medicaid is a joint federal and state program that finances the delivery of health care services to millions of low-income Americans. It is a means-tested program, and applicants must meet financial and other criteria in order to be eligible for services. Everyone who meets the eligibility criteria is entitled to Medicaid benefits available in their state of residence. Medicaid provides coverage for health care including primary and acute care as well as long-term services and supports to certain low-income adults, children, the elderly, and persons with disabilities. It is jointly funded by federal and state governments, and is administered by the states within federal

⁴² Currently, 14 states and DC have their own state-based exchanges and the remaining 36 states are participating in the Federally facilitated Marketplace or have State Partnership Marketplaces or supported State-based Marketplaces.

⁴³ The 2024 projected exchange enrollment of 25 million is partially offset by a decrease of 5 million in non-group coverage outside of the exchanges. A very small portion of this projected decrease includes other forms of coverage. Congressional Budget Office, "Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014," available at http://cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf.

⁴⁴ U.S. Census Bureau, Current Population Survey, *op. cit.*

⁴⁵ U.S. Census Bureau, Current Population Survey, *op. cit.*

⁴⁶ For additional information about Medicare, see CRS Report R40425, *Medicare Primer*.

⁴⁷ U.S. Census Bureau, Current Population Survey, *op. cit.*

guidelines. State Medicaid programs generally provide a comprehensive set of services, reflecting their diverse enrollee population. These programs must provide a set of federally specified benefits for qualified individuals, such as hospital services (both inpatient and outpatient), physician services, nursing home care for individuals aged 21 and over, home health care, and certain services for children. States may also cover additional *optional services* and beneficiaries. Some states have used waiver authority under Medicaid to extend coverage to uninsured persons who do not meet the program's categorical and/or financial tests.⁴⁸ ACA includes provisions that significantly expand eligibility for Medicaid beginning in 2014, although individual states can elect not to participate in this expansion.⁴⁹

The State Children's Health Insurance Program was established in 1997 to provide health coverage to uninsured low-income children who are ineligible for Medicaid. In designing their programs, states can choose among three options: expand Medicaid, create a separate CHIP program, or adopt a combination of both approaches. States that choose to expand Medicaid to CHIP eligibles must provide the full range of mandatory Medicaid benefits, as well as all optional services specified in their state Medicaid plans. States that establish CHIP programs that are separate from Medicaid choose one of three benefit options. All 50 states, the District of Columbia, and 5 territories have established some type of CHIP program. CHIP's eligibility rules target uninsured children under 19 years of age whose families' incomes are above Medicaid eligibility levels.

Military Servicemembers and Veterans

In 2013, approximately 14.1 million persons (4.5% of the U.S. population) were covered by health care services for military servicemembers and veterans.⁵⁰ Health care services for military servicemembers and veterans are provided by the Department of Defense (DOD) through TRICARE or by the Department of Veterans Affairs (VA) through the VA system and the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).

The DOD administers health care services through the TRICARE program to eligible beneficiaries that include active duty uniformed personnel, eligible members of the Reserve Component, uniformed services retirees; as well as their dependents and survivors. TRICARE is administered on a regional basis and provides health services through military and nonmilitary hospitals, clinics, and providers.⁵¹

The Department of Veterans Affairs, through the Veterans Health Administration, operates the nation's largest integrated direct health care delivery system. The VA system is a veteran-specific national health care system in which the federal government owns the medical facilities and employs the health care providers. VA health care eligibility is based on veteran status, presence of service-connected disabilities or exposures, income, and/ or other factors.⁵² Unlike TRICARE, VA health care covers a select group of dependents through CHAMPVA.⁵³

⁴⁸ For additional information about Medicaid, see CRS Report R43357, *Medicaid: An Overview*.

⁴⁹ For additional information about the expansion of Medicaid under ACA, see CRS Report R43564, *The ACA Medicaid Expansion*.

⁵⁰ U.S. Census Bureau, Current Population Survey, *op. cit.*

⁵¹ For additional information on TRICARE and the military health system, see CRS Report RL33537, *Military Medical Care: Questions and Answers*.

⁵² Other factors include status as a former prisoner of war or receipt of a Purple Heart.

⁵³ For additional information on health care for veterans and CHAMPVA, see CRS Report R42747, *Health Care for*

The Uninsured

Despite the multiple sources of public and private health insurance coverage, millions of Americans are without health coverage. In 2013, approximately 42 million people (13.4% of the U.S. population) were without coverage.⁵⁴ For the vast majority of the uninsured, they lack coverage because they cannot *access* coverage (e.g., their employer does not offer health insurance as an employment benefit) or they cannot *afford* it.

Uninsurance is characterized as a problem of the under-65 population, given near-universal coverage of seniors through Medicare. One of the most striking characteristics of persons who lack coverage is that a significant proportion are in low-income families. For instance, among all uninsured persons under age 65, well over half were in poor or near-poor families in 2012.⁵⁵

A defining characteristic of the nonelderly uninsured population is that most have ties to the paid labor force. In 2012, “just over 80 percent of the uninsured lived in families headed by workers.”⁵⁶ While such findings may be counter-intuitive, there are multiple reasons why employed persons and their families may lack health coverage. For example, a worker may be offered health insurance by his/her employer, but declines it because he/she thinks it is too expensive. An employee may work for a small firm which is less likely than a large firm to offer health insurance as a benefit. Finally, a healthy worker may be willing to take on the risk of being uninsured and choose not to purchase insurance at all. So, despite the dominance of employer-sponsored health insurance, the dynamics of employment status, health conditions, and financial resources intersect to historically impede coverage of all workers and their families.

Consequences of Uninsurance

While health insurance coverage is not necessary to obtain health care, it is a useful mechanism for accessing services in an environment of increasingly expensive health care. As health care costs continue to rise, more people need greater assistance with covering medical expenses. Health insurance provides some measure of protection for consumers, especially for those who have limited means or greater-than-average need for medical care.

Health insurance is considered important also because of the well-documented, far-reaching consequences of uninsurance. For instance, uninsured persons are more likely to forgo needed health care than people with health coverage.⁵⁷ This includes forgoing services for preventable or chronic conditions, which often leads to worse health outcomes. Uninsured persons also are less likely to have a *usual source of care*, that is, a person or place identified as the source to which the consumer *usually* goes for health services or medical advice (not including emergency rooms). Having a usual source is important because people who establish ongoing relationships

Veterans: Answers to Frequently Asked Questions.

⁵⁴ U.S. Census Bureau, Current Population Survey, *op. cit.*

⁵⁵ Persons with income at or below 250% of the federal poverty level accounted for about 75% of all nonelderly uninsured individuals in 2012. Kaiser Family Foundation, “The Uninsured: A Primer— Key Facts about Health Insurance on the Eve of Coverage Expansions,” October 2013, <http://kff.org/uninsured/report/the-uninsured-a-primer-key-facts-about-health-insurance-on-the-eve-of-coverage-expansions/>.

⁵⁶ *Ibid.*, p. 17.

⁵⁷ Kaiser Commission on Medicaid and the Uninsured, “The Uninsured and the Difference Health Insurance Makes,” October 2011, <http://www.kff.org/uninsured/upload/1420-13.pdf>.

with health care providers or facilities are more likely to access preventive health services and have regular visits with a physician, compared with individuals without a usual source.⁵⁸

The ACA now requires most individuals to maintain health insurance coverage for themselves and their dependents, or otherwise pay a penalty. Some individuals are exempt⁵⁹ from the individual mandate and the penalty. Individuals who do not maintain minimum essential coverage and are not exempt from the mandate will have to pay a penalty for each month of noncompliance. In 2014, the annual penalty was the greater of \$95 or 1% of applicable income. In 2015, the annual penalty is the greater of \$325 or 2% of applicable income.⁶⁰

Expanding coverage is one of the primary objectives of the ACA. The Congressional Budget Office and the Joint Committee on Taxation estimated that ACA will increase the number of nonelderly Americans with health insurance by about 26 million by 2024 relative to the projected trend without ACA. The share of nonelderly U.S. residents with insurance coverage in 2024 is estimated to be around 89%, compared with a projected share of around 80% in the absence of the law. However, approximately 31 million nonelderly U.S. residents are estimated to remain uninsured, including individuals who choose not to purchase health insurance and are subject to the penalty for noncompliance to the ACA's individual mandate, individuals who are exempt from the individual mandate, and undocumented individuals.⁶¹

Conclusion

Health insurance in the United States is a patchwork comprised of a combination of private and government sources. In 2013, a majority (64.2%) of Americans obtained health insurance through the private sector, which includes both employer-sponsored and non-group coverage. Public programs (Medicare, Medicaid/CHIP, or health care services for military servicemembers and veterans) provided coverage to 34.3% of Americans. Approximately 13.4% of Americans were uninsured for the entire year of 2013.^{62,63}

Within each of the sources, health insurance differs by the market structure itself—group versus non-group, fully insured versus self-insured; self-only versus family coverage, etc. Overlaying this patchwork are also regulations from both the federal and state level. In addition, the ACA instituted a large set of reforms to the private insurance market and expanded publicly funded coverage. Health care is also delivered and financed through different arrangements (e.g., indemnity insurance, managed care, and consumer-driven health care), which are further discussed in the **Appendix**. The popularity of some of these mechanisms has also changed over time.

⁵⁸ Agency for Healthcare Research and Quality, “National Healthcare Disparities Report, 2013,” May 2014, <http://www.ahrq.gov/research/findings/nhqrdr/nhdr13/2013nhdr.pdf>.

⁵⁹ There are many different types of exemptions, such as hardship, affordability, qualifying religious reasons, membership in health care sharing ministry, not lawfully present in the U.S., etc.

⁶⁰ For additional information on the individual mandate, see CRS Report R41331, *Individual Mandate Under the ACA*.

⁶¹ Congressional Budget Office, “Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014.” Available at http://cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf.

⁶² U.S. Census Bureau, Current Population Survey, “Health Insurance Coverage in the United States: 2013,” September 2014, available at <http://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-250.pdf>.

⁶³ Individuals may report more than one source of coverage, and individuals may report both private insurance and insurance through public programs; therefore, percentages total to more than 100.

Appendix. How Is Private Health Coverage Provided?

Given the complexity of the health care system overall, it is no surprise that health coverage is delivered and financed through different arrangements. Those arrangements vary due to numerous factors such as how health care is financed, how much access to providers and services is controlled, and how much flexibility the enrollees have to use the services covered under her/his health plan. While delivery systems may share certain characteristics, general distinctions can be made based on payment, access, and other critical variables.

Indemnity Insurance

Under indemnity insurance, the insured person decides when and from whom to seek health services. If the services the enrollee receives are covered under his/her insurance, the enrollee or the enrollee's provider files a claim with the insurer. Thus, insurers make payments *retrospectively* (i.e., after the health services have been rendered), up to the maximum amounts specified for each covered service. In this model of health care delivery, the financing of health services and the obtaining of those services are kept separate.

This bifurcated arrangement was unquestioned for a time. But as medical costs began to rise, sometimes faster than other sectors of the national economy, many observers criticized this delivery model as contributing to increasing expenditures. Because providers were compensated on a fee-for-service basis, some argued that providers were not given incentives to provide efficient health care. In fact, some critics accused health care practitioners and institutions of providing an over-abundance of health care in order to generate greater revenue.⁶⁴ By the early 1970s, legislators, analysts, and others expressed considerable interest in alternative models, such as managed care models, with cost control as a key feature.

Managed Care

While managed care means different things to different people, several key characteristics set it apart from traditional (indemnity) insurance. One of the main differences is that the service delivery and financing functions are integrated under managed care. Managed care organizations (MCOs) employ various techniques to control costs and manage health service use *prospectively*. Among those techniques are restricting enrollee access to certain providers (*in-network* providers); requiring primary-care-physician approval for access to specialty care (*gatekeeping*); coordinating care for persons with certain conditions (*disease management* or *case management*); and requiring prior authorization for routine hospital inpatient care (*pre-certification*). MCOs may offer different types of health plans that vary in the degree to which cost and medical decision-making is controlled. As a consequence, enrollee costs also vary. Generally, the more tightly managed a plan is, the lower the premium. Other distinguishing features of the managed care approach include an emphasis on preventive health care and implementation of quality assurance processes.

Managed care was touted as the antidote to rapidly rising health care costs. Starting with the passage of federal legislation in the 1970s which supported the growth of managed care (specifically in the form of health maintenance organizations (HMOs)), the number of MCOs

⁶⁴ "The Role of Prepaid Group Practice in Relieving the Medical Care Crisis," Harvard Law Review, vol. 84, no. 4 (February 1971), pp. 887-1001. Available at <http://www.jstor.org/stable/1339782>.

grew quickly. Increased market competition among these organizations led to decreases in premiums, in order to gain market share. With high medical inflation in the 1980s and early 1990s, enrollees flocked to these less-costly managed care plans. By the mid-1990s, more insured workers were enrolled in HMOs than any other health plan type—contributing to the substantial displacement of traditional indemnity insurance⁶⁵—and health insurance premiums had stabilized.⁶⁶

But in the latter half of the 1990s, a *backlash* against managed care started to grow.⁶⁷ Some enrollees had grown weary of provider and service restrictions. Many MCOs that had increased market share through artificially low premiums began to raise them in order to increase revenue.⁶⁸ Consumers and others accused the managed care industry of caring more about controlling costs than providing health care.⁶⁹ Some providers resented the role managed care played in medical decision-making. Many enrollees began to leave HMOs. The industry responded by developing insurance products that were less-tightly managed, but more costly. Some traditional HMOs widened their provider networks and eliminated the gatekeeping function, while employers began to offer plan types that were less tightly managed, such as preferred provider organizations (PPOs).⁷⁰ In fact, by the end of the 1990s, more people with work-based health coverage were enrolled in PPOs than in HMOs.⁷¹

As the influence of managed care waned and health care costs began to rise at an increasing pace during the late 1990s, consumers began to feel the impact. For example, in the employment setting, employers absorbed the extra costs at first in order to recruit and retain workers during the booming economy of the mid to late 1990s.⁷² But as the economy soured, employers began to pass these expenses along to enrollees by increasing employees' contributions to their own coverage.⁷³

Consumer-Driven Health Care

By the end of the 1990s, large increases in health costs again became commonplace. With the belief by some observers that the age of managed care was over, they began to search for alternatives. Consumer-driven (or consumer-directed) health care has been offered as one such option.

⁶⁵ The Kaiser Family Foundation and Health Research and Educational Trust, *2014 Employer Health Benefits Survey*, available at <http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report>.

⁶⁶ Jon Gabel et al., "Job-Based Health Benefits in 2002: Some Important Trends," *Health Affairs*, vol. 21, no. 5, pp. 143-151.

⁶⁷ Richard Kronick, "Waiting for Godot: Wishes and Worries in Managed Care," *Journal of Health Politics, Policy and Law*, vol. 24, no. 5, pp. 1099-1106.

⁶⁸ Jon Gabel et al., "Job-Based Health Insurance in 2001: Inflation Hits Double Digits, Managed Care Retreats," *Health Affairs*, vol. 20, no. 5, pp. 180-186.

⁶⁹ Firshein J, Sandy LG. The changing approach to managed care. In: Isaacs SL, Knickman JR, eds. *To Improve Health and Health Care 2001: The Robert Wood Johnson Anthology*. San Francisco: Jossey-Bass; 2001:77-100.

⁷⁰ PPOs allow plan participants and beneficiaries to use any health care provider, but offer lower cost-sharing when individuals use in-network providers, with whom the insurer has negotiated rates.

⁷¹ The Kaiser Family Foundation and Health Research and Educational Trust, *2014 Employer Health Benefits Survey*, available at <http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report>.

⁷² Jon B. Christianson and Sally Trude, "Managing Costs, Managing Benefits: Employer Decisions in Local Health Care Markets," *Health Services Research*, pt. II, vol. 38, no. 1, pp. 357-373.

⁷³ Jon Gabel et al., "Job-Based Health Benefits in 2002: Some Important Trends," *Health Affairs*, vol. 21, no. 5, pp. 143-151.

Consumer-driven health care refers to a broad spectrum of coverage arrangements that give incentives to consumers to control their use of health services and/or ration their own health benefits. While consumer-driven health care can take on many forms, the premise common to all of these approaches is that by making enrollees more responsible for the cost of their own health care, it creates incentives for people to use services prudently. The expectation is that greater cost-consciousness on the part of consumers will result in lower overall health costs. In essence, the service and cost control functions administered by MCOs and providers under managed care shifts in part to enrollees under the consumer-driven health care model.

One example that is at the heart of discussions about consumer-driven care is the health savings account (HSA). An HSA, in and of itself, is not a health insurance plan. Instead, it is an investment account in which contributions earn interest tax free. Consumers, their employers, or both may make contributions to HSAs. Consumers withdraw funds on a tax-free basis to cover medical expenses not covered by health insurance. Unused contributions roll over to the next year. HSAs are paired with high-deductible health plans. If the HSA funds are exhausted and the deductible level has not been reached, the consumer is responsible for covering that gap. Once the consumer's spending reaches the deductible level, then coverage from the health plan takes effect. HSAs were authorized in November 2003 under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173).

Proponents of consumer-directed health care assert the merit in having people take increased responsibility for their own health care use and expenses. They predict that this approach will lead to better-informed consumers, more appropriate use of health services, and lower overall spending on health care. Opponents express concern that this approach does not recognize the possible range of health conditions in an enrolled population; and imposes a greater burden on individuals with moderate to severe health conditions. Also, opponents point out that the tax advantages of such insurance arrangements benefit the wealthy to a greater extent than those less well off.

Recent Enrollment Trends

From the mid-1990s to 2014, HMOs continued to become proportionally less popular among covered workers, declining to a 13% share of the employer-sponsored insurance market in 2014 after reaching a 31% share in 1996. For more than a decade, PPOs have made up the majority (58% share in 2014) of employer-sponsored plans—contributing to the displacement of conventional indemnity coverage, which has by now all but disappeared from the private market. PPO plans, which combine moderate provider network restrictions with increased patient freedom relative to HMOs, remain the dominant form of worker coverage today. High-deductible coverage paired with HSAs and other savings account arrangements have also made inroads in the market, making up about a fifth of employer-sponsored enrollment by 2014.⁷⁴

The individual insurance market has seen a similar distribution of plan types. Surveys taken of health insurers show that for the individual market, just as for the group market, PPOs are the most popular option; in fact, they are overwhelmingly popular, accounting for more than 80% of self-only plans and more than 70% of family plans in 2009. In contrast, HMOs are relatively

⁷⁴ The Kaiser Family Foundation and Health Research and Educational Trust, *2014 Employer Health Benefits Survey*, available at <http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report>.

unpopular, with HMO plans declining from about 6% of self-only plans in 2004 to about 2% in 2009.⁷⁵

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⁷⁵ America's Health Insurance Plans Center for Policy and Research, *Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability, and Benefits*. October 2009. Available at <http://www.ahip.org/Individual-Health-Insurance-Survey-2009/>. America's Health Insurance Plans Center for Policy and Research. *Individual Health Insurance: A Comprehensive Survey of Affordability, Access, and Benefits*. August 2005. Available at http://heartland.org/sites/all/modules/custom/heartland_migration/files/pdfs/17693.pdf. Plan type information was not grouped in the same way across survey years, potentially leading to slight discrepancies between surveys. However, the broader picture illustrated by the numbers is correct.